Information must be sought from multiple sources. These sources include the following: interviews or discussion with resident and direct care staff on all three shifts, including weekends; review of documentation used for staff communication across the three shifts; the assessor's own observation of the resident performing certain tasks (if possible). If therapies are involved with the resident, their input should be included either by way of an interview with the therapist or by the assessor reviewing the therapy documentation. The resident may perform differently in therapy than on the unit.

When discussing self-performance with direct care staff, residents or therapists, it is important to ask questions related to all aspects of the ADL activity. For example, when discussing bed mobility with a CNA, be sure to ask how the resident moves to and from a lying position, how the resident turns from side to side, and how the resident accomplishes positioning while in bed. A resident may be independent in one aspect of Bed Mobility, and require extensive assistance in another aspect. Also key in on occurrences of exceptions in the resident's performance. When discussing a resident's ADL performance with a therapist, make sure the therapist's information can be expressed in MDS terminology.

QUESTION 3 - 42: I was advised that all nursing home residents should be coded as "supervision" under self-performance in eating at Item G1hA, because there should always be someone supervising the residents as they eat. Is this correct?

No. General supervision of a dining room is not the same as individual supervision of a resident. If the resident ate independently, then MDS Item G1hA is coded as "0" (Independent). If the individual resident needed oversight, encouragement, or cuing during the last 7 days, the Item is coded as a "1" (Supervision). For a resident who has received oversight, encouragement, or cuing and also received more help, such as physical assistance provided one or two times during the 7 day assessment period, the resident would still be coded as a "1" (Supervision). Residents who are in "feeding" or "eating" groups and who are individually supervised during the meal, would be coded as "1" (Supervision), for Self Performance in Eating.

QUESTION 3 - 43: How can we differentiate between guided maneuvering and weight-bearing assistance when coding self-performance in eating, at MDS Item G1hA?

The key to the differentiation is determining *who* is supporting the weight of the resident's hand. If the staff member supports some of the weight of the resident's hand while helping them to eat, (e.g., lifting a spoon or a cup to mouth), this is "weight-bearing" assistance for this activity. If the resident can lift

the utensil or cup, but staff assistance is needed to guide the resident's hand to his/her mouth, this is guided maneuvering.

QUESTION 3 - 44: In our facility the rehabilitation notes are often used to code the Items at G4 (Functional Limitation in Range of Motion). However, for the long-stay residents, these evaluations are not always in the current chart.

In developing the User's Manual, we recognized that this was likely to happen. If no assessment has been conducted and documented by a therapist within the last seven days, then a clinical professional (e.g., nurse) may assess this area following the guidance in the RAI User's Manual. Detailed instructions on how to perform the functional range of motion tests and voluntary movement tests begin on page 3-95 of the Manual. In this Item we are moving from performance issues to structural issues. We are not asking how an activity is carried out; we are determining the structural ability of the limbs to move.

QUESTION 3 - 45: There is a statement on page 3-96 of the RAI User's Manual that needs to be clarified. It reads, " at Item G4 code the appropriate response of the resident's active (or assisted passive) ROM function during the past 7 days." It seems to me that passive movement is not assisted; rather it is performed for the resident. On the other hand, active movement can be assisted to complete the ROM. I think the term "assisted" should be left out of the statement.

The term "assisted passive" should read "assistive/passive" as stated at the top of the page 3-96. Read "/ " as "or".

QUESTION 3 - 46: If a gait belt is used when transferring a resident, should Item G6e (transfer aid) be checked?

If the gait belt is used during transfer of the resident, then Item G6e "transfer aid" should be checked.

Questions on Items in MDS Section H

QUESTION 3 - 47: It is difficult to make the correct selection on the continence scale when coding for bowel continence (H1a) and bladder continence (H1b). What is the best way to ensure accurate coding?

According to the RAI Users' Manual (pg. 3 – 106) assessors must use multiple sources of information to code accurately: resident interview and observation, review of the clinical record (i.e., urinary and bowel elimination flow sheets), and discussions with direct care staff across all shifts.

The keys to obtaining, tracking and recording accurate information in Section H are 1) interviews with and observations of residents, and 2) communication between licensed and non-licensed staff and other caregivers (Refer to the RAI User's Manual, pages 3-105 through 3-110).

- Daily communication between nurses, certified nurse assistants (CNAs) and other direct care providers across all shifts is crucial for resident monitoring and care giving in this area. Staff who work most closely with residents will know how often they are dry or wet.
- Focus your assessment over the last 14 days. When getting information about continence from CNA's start to narrow your questions to focus on either end of the continence scale, then work your way to the middle. For example using the urinary continence scale, if the resident is always dry, code "0", (Continent). If the resident is always wet, and has no control, code "4", (Incontinent). If incontinence occurs only once a week, or less, code "1", (Usually continent). The difference between code "2" (Occasionally incontinent), and code "3" (Frequently incontinent) is that for code "3", the resident is incontinent at least daily or multiple times a day.

QUESTION 3 - 48: If a fecal impaction located in the rectum was noted by x-ray, but not by digital exam, should it still be coded on the MDS at Item H2d? The definition in the RAI User's Manual instructs the assessor to code a fecal impaction if it is seen on a x-ray in the sigmoid colon or higher.

The definition in the RAI User's Manual discusses the usual case. It does not provide for excluding from MDS coding fecal impaction detected elsewhere. Fecal impaction should always be coded whether it is detected by physical exam, x-ray or any other method.

QUESTION 3 - 49: If the resident's incontinence briefs, pads, or linens are changed every two hours or when they are wet, should we check "scheduled toileting plan" (MDS Item H3a in the "Appliances and Programs" section)?

No. There are 3 key ideas captured in Item H3a: 1) scheduled, 2) toileting, and 3) program. The word "scheduled" refers to performing the activity according to a specific, routine time that has been clearly communicated to the resident (as

appropriate) and caregivers. The concept of "toileting" refers to voiding in a bathroom or commode, or voiding into another appropriate receptacle (i.e., urinal, bedpan). Changing wet garments is not included in this concept. A "program" refers to a specific approach that is organized, planned, documented, monitored and evaluated. A scheduled toileting program could include taking the resident to the toilet, providing a bedpan at scheduled times, or verbally prompting to void. Refer to the RAI User's Manual Version 2.0, p. 3-108.

QUESTION 3 - 50: A Certified Nurse Assistant (CNA) walks the resident to the bathroom according to a scheduled program (upon arising, after each meal, and at bedtime) five times per day. However, between these times the resident is often incontinent of bladder. Should we still check Item H3a, "scheduled toileting plan"?

Yes. If the scheduled plan is recorded in the care plan and staff are actually toileting the resident according to the multiple specified times, check Item H3a. If the resident is on a scheduled toileting program and is still incontinent of bladder, record the resident's level of bladder continence in Item H1b. In view of the resident's breakthrough incontinence, this would be a good time to reevaluate the effectiveness of the current plan by assessing if the resident has a new, reversible condition causing a decline in continence (e.g., UTI; mobility problem; etc.), and treating the underlying cause. Also determine whether there is a pattern to the extra times the resident is incontinent and consider adjusting the scheduled toileting plan accordingly.

Questions on Items in MDS Section K

QUESTION 3 - 51: A resident is identified as having a swallowing problem that has been handled with successful care plan interventions (thickened liquids, speech therapy). At the time of an MDS assessment, the resident does not exhibit the signs of dysphagia, therefore the assessor leaves K1b blank. Isn't the resident still at risk for complications or injury due to the dysphagia?

This is an example of a problem identified by the interdisciplinary team that has not "triggered" a RAP. A plan of care must be developed to address the problem and prevent complications. The problem exists and it is obvious from this example that the facility has developed an appropriate plan of care.

QUESTION 3 - 52: Regarding MDS Item K3a, we often have difficulty determining if there has been a 5% or more weight loss in the last 30 days,

or a 10% or more weight loss in the last 180 days. Our dietary documentation refers to Ideal Body Weight (IBW) and not to weights obtained in prior time periods.

Good clinical practice dictates that facilities monitor and record height and weight as part of the monitoring of a resident's health status. To code Item K3 (Weight change) accurately, the facility must obtain a resident's weight at the 30 day and 180 daytime periods.

QUESTION 3 - 53: How can the percentages be calculated to accurately code Item K3a (Weight Loss)?

The first step in calculating percent weight loss is to obtain the weights for the 30 day and 180 day time periods from the resident's clinical record. The calculation is as follows:

a. Start with the resident's weight from 30 days ago and multiply it by the proportion (0.05). If the resident has gained or lost more than this 5%, code a "1" for Yes at Item K3a.

b. Start with the resident's weight from 180 days ago and multiply it by the proportion (0.10). If the resident has gained or lost more than this 10%, code a "1" for Yes at Item K3a.

There are also charts available that make it easy for staff to calculate the percent of weight lost or gained.

QUESTION 3 - 54: Should Item K5e, (Therapeutic diet) be checked if a resident is on a "no added salt" (NAS) diet?

Yes. A no added salt diet ordered by the physician is considered a therapeutic diet.

QUESTION 3 - 55: Is there a requirement as to the amount or frequency of nutritional supplements in order to include them at Item K5f (Dietary Supplement) as a nutritional approach?

There is no requirement specifying the amount or frequency of nutritional supplements. The RAI User's Manual p. 3-130 states "Any type of dietary supplement provided between meals." This Item does not include supplements provided at meal times.

Questions on Items in MDS Section M

QUESTION 3 - 56: When coding skin condition Items in Section M, are assessors required to perform a physical assessment of skin, or can the information be obtained through clinical record review?

In general, MDS coding instructions call for the use of multiple sources of information to enhance coding accuracy. Unless the RAI User's Manual specifies to do so, assessors should not rely on the clinical record as the sole source of information about the presence or absence of any condition.

A skin examination is necessary for problem identification and accurate coding of Section M. The RAI User's Manual, page 3-135, states "Examine the resident…Without a full body check, an ulcer can be missed." This examination must be performed by a clinician knowledgeable in the process of evaluating skin integrity. It does not necessarily have to be performed by the assessor completing the MDS form. Some facilities have found that it is more convenient for staff, as well as for residents, when the skin assessment is conducted during bathing or dressing activities.

QUESTION 3 - 57: Should a blister in the incontinence brief area (e.g., irritation causing a blister on the front of the torso) be recorded at Item M1 (Ulcer due to any cause) as a Stage 2 Ulcer? Should it be coded as a pressure ulcer for Item M2a?

At Item M1, code ulcers that correspond to the definitions provided on the form and in the RAI User's Manual on pages 3-134 and 3-135, regardless of the cause of the ulcer. A Stage 2 Ulcer is defined as "A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater". In this case, a blister in the incontinence brief area should be considered as a Stage 2 ulcer at Item M1.

In order to code Item M2a (Pressure ulcer) the key is to determine if there was a source of pressure that caused the blister. In the presence of moisture, less pressure may be required to develop a pressure ulcer. If, for example, the blister was found in the area of the incontinence brief waist or leg band, pressure from the band is a likely cause of the blister and the assessor would record the blister as a pressure ulcer. If no source of pressure could be identified, the blister may be evidence of perineal dermatitis caused by excessive urine or stool eroding the epidermis. No pressure is required for perineal dermatitis to occur. If this is the case, the blister would not be recorded as a pressure ulcer but would be considered a rash, and Item M4d (Rashes) would be checked. Refer to the RAI

User's Manual, p. 3-137.

For additional information, refer to: Lyder, C. (1997). Perineal dermatitis in the elderly: A critical review of the literature. Journal of Gerontological Nursing 23(12), 5-10.

QUESTION 3 - 58: After a pressure ulcer Stage II - IV has been debrided, should assessors stop coding it in Section M1 (Ulcers)?

No. Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The ulcer still exists, and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate at Item M5, (Skin Treatments).

QUESTION 3 - 59: Should the Pressure Ulcer Scales for Healing (PUSH), or reverse staging, be used when coding the appearance of an ulcer at MDS Item M1?

Continue to use reverse staging for version 2.0 of the MDS, as per the Item coding instructions in the RAI User's Manual, beginning on page 3-134. CMS is considering incorporating the PUSH scale in a future iteration of the MDS.

QUESTION 3 - 60: One of our residents has 5 open wounds as a result of frostbite and not pressure or venous stasis. Upon examination, these wounds meet the criteria provided in Item M1 (Ulcers) coding definitions: 4 of them are consistent with Stage 2 ulcer staging, and 1 of them appears to be at Stage 3. How should these be recorded in Section M, Skin Conditions?

This is an interesting case where the resident does not fit the type of skin problems commonly seen in nursing facilities. Assuming that the resident in this scenario has no stasis or pressure ulcers, code the resident's condition as follows:

- Item M1, Ulcers (due to any cause). Because this Item does not require that the cause of the ulcer be known:
  - M1a. Stage 1, code "0" (no ulcers at stage 1)
  - M1b. Stage 2, code "4" (4 ulcers at stage 2)
  - M1c. Stage 3, code "1" (1 ulcer at stage 3)
  - M1d. Stage 4, code "0" (no ulcers at stage 4)
- Item M2, Type of ulcer:

M2a. Pressure ulcer, code "0" (highest stage ulcer is not a pressure ulcer)
M2b. Stasis ulcer, code "0" (highest stage ulcer is not a stasis ulcer)

Be sure to examine the resident and code Section M for other skin conditions, including those of the feet, as well as treatments being provided. Also enter the appropriate ICD-9 code for "frostbite" as specified in the 991.0 - 991.3 ICD-9 series in Section I3, Other diagnoses.

QUESTION 3 - 61: If a resident has redness and excoriation over her buttocks related to multiple daily incontinent episodes of diarrhea, should the redness be coded in Item M1 (Ulcers due to any cause), as a Stage 1 ulcer (M1a = 1) and as a rash (M4d = checked)? It does not seem that pressure is the cause of this redness.

If there is persistent redness without a break in the skin that does not disappear when pressure is relieved, the problem should be recorded as a Stage 1 ulcer (M1a=1). Less pressure is needed for a pressure ulcer to form when the skin is soiled with urine and/or feces. If the resident has compromised mobility, pressure is very likely and Item M1a should be coded as "1". If this is a situation where the redness is from pressure and a contact rash from incontinence, especially if the resident was wet long enough to develop the rash, code, M2a (pressure ulcer) and M4d (rashes). If the resident's mobility status is not impaired and the redness is not likely due to pressure, code M4d (rash). In this scenario, the incontinent episodes of diarrhea should be coded at Item H1a (Bowel Continence). This should also be coded at H2c (Diarrhea), if appropriate.

QUESTION 3 - 62: Should all skin and foot problems that were coded on a prior assessment at Items M4 (Other skin problems) and M6 (Foot problems and care), also be recorded on the current MDS assessment, even if they are healing?

Yes. Even if they were already recorded on a prior MDS assessment and are now healing, all problems and lesions present during the current observation period should be documented on the MDS. These Items refer to the objective presence of problems or lesions, not the status of such. Refer to the RAI User's Manual, p. 3-137 to 140.

QUESTION 3 - 63: Is it necessary to have supporting clinical record documentation of treatments listed in Item M5 (Skin treatments, e.g., turning and repositioning program; application of ointments) and M6 (Foot

problems and care, e.g., trimming of nails/calluses; and application of dressings)?

Yes. It's a matter of good clinical practice to have such documentation. Some facilities have found flow sheets useful for this purpose. The form and format of such documentation is determined by the facility.

In answer to this inquiry, and in general concerning documentation that supports clinical practice (including resident assessment), refer to the CMS March 2001 publication of RAI Version 2.0 Q & A's (Question 2-2, p. 3), The following is excerpted from that document:

"… completion of the MDS does not obviate the facility's responsibility to document a more detailed assessment of particular issues of relevance to the resident (e.g., as might be discovered through the RAPs, or by assessing areas not included or covered in sufficient depth on the MDS). Facilities are also required to document the resident's care and response to care during the course of the stay and it is expected that this documentation would chronicle, support and be consistent with the findings of each MDS assessment or quarterly review and related care issues. Bear in mind that government requirements are not the only reason for clinical documentation. The MDS system has codified some documentation requirements into a standard format. In addition, clinical documentation that contributes to the identification and communication of residents' problems, needs and strengths, that monitors their condition on an on-going basis, and that records the treatment and response to treatment, is a matter of good clinical practice and is an expectation of trained and licensed health care professionals."

It is up to the facility to determine the form and format of such documentation.

QUESTION 3 - 64: Should the use of a chair pad or mattress that has been defined by the manufacturer as "pressure relieving" be checked in Item M5a (Pressure relieving device for chair) or M5b (Pressure relieving device for bed)?

Yes. If the pressure-relieving device was used in the observation period, check M5a if it was for a chair, and M5b if it was for a bed. However, do not check either Item if the device was an egg crate cushion or mattress. These are specifically excluded from coding, as specified in the RAI User's Manual on page 3-139.

QUESTION 3 - 65: Must dressings be changed daily in order to be recorded at Item M5e (Ulcer care), M5f (Surgical wound care), M5g (Application of dressings [other than to feet]), or M6f (Application of dressings [to the

foot])?

No. The RAI User's Manual pp. 3-138 to 3-140 provides definitions for these MDS Items and instructs the assessor to "check all that apply" during the 7-day observation period. Thus, if any dressing meeting the MDS definitions provided for Items M5e, M5f, M5g or M6f was applied even once during the 7-day period, the assessor would check the appropriate MDS Item.

Questions on Items in MDS Section N

QUESTION 3 - 66: Please expand on the coding instructions on page 3-141 of the RAI User's Manual for Item N1 (Time Awake), by offering examples and discussing appropriate methods of information gathering.

Item N1, "Time Awake", identifies periods of the day when a resident is typically awake all or most of the time. The time periods, Morning (Item N1a), Afternoon (Item N1b), and Evening (Item N1c), are defined for each individual resident based on when they typically wake up in the morning and are asleep at night. Morning is generally defined as between 7:00 am and noon. But for a resident who typically wakes up earlier, (e.g., at 6:00 am), then the morning period for that resident is 6:00 am until noon. Afternoon is always defined as between noon and 5:00 pm. Evening is generally defined as between 5:00 pm and 10:00 pm. But for a resident who is typically asleep earlier, (e.g., at 9:00 pm), then the evening time period for that resident is between 5:00 pm and 9:00 pm. When coding Items N1a, b and c, check each time period, as defined for that resident, during which he or she did not nap for more than one hour.

Some examples of coding Item N1 are as follows:

- A resident wakes up every morning at 7:00 am. He typically eats breakfast, has a shower, gets dressed and goes back to bed for a late morning nap from 10:00 am until 11:30 am. Item N1a (Morning) should NOT be checked, since this resident typically naps for more than 1 hour during the morning.

- A resident typically wakes up at 6:00 am. She is busy with therapy and activities most of the day, and does not take naps. She goes to bed by 7:00 pm every evening. Items N1a (Morning), N1b (Afternoon) and N1c (Evening) should all be checked, since this resident does not take naps.

- A resident who is bedfast and has end-stage Alzheimer's disease wakes up at 6:00 am daily. She typically dozes off throughout day, napping for more than 1 hour before noon, and again from 3:30 pm to 5:30 pm every afternoon. She is typically awake from 5:30 until 9:00 pm. After that, she's asleep for the night. Items N1a (Morning) and N1b (Afternoon) should NOT be checked, since this resident naps for more than one hour during each of these periods. Item N1c (Evening) should be checked as time awake. Although this resident sleeps until 5:30 pm, that is only a 30-minute naptime in the Evening period.

In general, accurate coding of MDS Items relies on the use of the Item coding instructions in the RAI User's Manual, and the use of appropriate information gathering techniques. Coding Items N1a, b, and c, based on only the assessor's personal knowledge of a resident's sleep and awake patterns might not result in an accurate response. Documentation review is important. However, since we would generally not expect facility staff to maintain flowcharts for information such as sleep and awake times, documentation is not always available. Therefore, it's important to observe the resident across all shifts. In addition, the same individual staff member is generally not on duty and available to observe a resident across a 24 hour period. That's why it's important to supplement observation with interviews of the resident, their family members, other staff across shifts, and in particular, the CNAs who care for that resident.

Questions on Items in MDS Section O

QUESTION 3 - 67: The RAI User's Manual, as well as previously released Q & A's are clear that, for the purposes of MDS coding, vitamins should be counted when coding Section O (Medications). What if a resident receives a dietary supplement between meals that includes a vitamin as one of its ingredients? Should that be coded as a dietary supplement, or as a medication?

If a dietary supplement given to a resident between meals has a vitamin as one of its ingredients, code it as a dietary supplement, *not* as a medication.

Coding Examples:
If a resident receives a daily Vitamin C capsule, add it to the medication count in number of medications (O1).

If a resident receives a dietary supplement between meals and the label contents specify that Vitamin C (or any other vitamin, etc) is one of the ingredients, code

(K5a = check) for dietary supplement between meals.

QUESTION 3 - 68: If an herbal remedy or other natural/alternative product contains a vitamin as one of its ingredients, should it be counted as a medication when coding Section O?

No. Herbal remedies or other natural/alternative products should not be coded as a medication.

QUESTION 3 - 69: Are PPD tests for tuberculosis, or vaccines (e.g., influenza, and pneumovax) to be coded under injections at MDS Item O3, when given in the observation period?

For MDS Item 03, the RAI Users' Manual (p.146) specifies to record the number of DAYS during the past 7 days the resident received any type of medication, antigen, vaccine, by subcutaneous, intramuscular, or intradermal injection"...including "biologicals", so one can track for localized or systemic reactions. Assuming these are the only injections given in the observation period - if the resident received one of these injections on one day, and the other on a different day, code "2" for the number of days the resident received injections. If both injections were given on the same day, code "1". Also include these when coding Item O1 (Number of medications).

QUESTION 3 - 70: Question numbers 97 and 98 in the CMS 1996 Q & A publication state to code a medication in Item O4 (Days Received the Following Medication) for its classification, and not its use. If a medication has more than one classification, how should it be coded? For example, phenobarbitol is considered an anticonvulsant and a barbiturate. It is listed in Appendix E in the RAI User's Manual (p. E-1) under antianxiety drug. If Phenobarbital was given daily for control of seizure activity, should the number of days the resident received it be recorded at MDS Item O4b, Antianxiety drug? And if so, would it be correct to explain the medication use in the care planning process?

Continue to code a medication for its classification not its use at MDS Item 04. In this case code Item O4 (antianxiety drug) as "7" days. Consider the drug's intended use, effectiveness and all potential side effects in the care planning process, and monitor accordingly.

Questions on Items in MDS Section P

QUESTION 3 - 71: We had a resident who received therapy 6 out of the 7 days in the observation period, totaling 65 minutes over the 6 days. The therapy session lasted 15 minutes on only one of those days. The sessions lasted 10 minutes each of the remaining 5 days. How should Item P1bA (number of DAYS administered for 15 minutes or more) and Item P1bB (total number of MINUTES provided in the last 7 days) be coded?

At MDS Item P1bA, record the number of days in the observation period that therapy was given for 15 minutes or more. In column P1bB, record the total number of minutes therapy was administered during the observation period, (even if it was less than 15 minutes on any of the days).

In the above scenario, only one day of therapy would be recorded at Item P1bA, since there was only one day in the observation period that the resident received at least 15 minutes of therapy. The entire 65 minutes should be recorded at Item P1bB.

The Item coding instructions appear on the form as well as in the RAI User's Manual, page 3-151.

QUESTION 3 - 72: Do the actual number of minutes of therapy provided to each resident have to be recorded at MDS Item P1bB (total number of minutes provided in the last 7 days)?

Yes. The Item description on the form, as well as the description and coding instructions in the RAI User's Manual, page 3-151, state to code the total number of minutes therapy was provided in the 7 day observation period. Time spent on documentation or on initial evaluation cannot be included. Time spent on periodic reevaluations conducted during the course of a therapy treatment, may be included.

QUESTION 3 - 73: How do I code MDS Items P1bA and P1bB when it is recorded in the therapy notes that the resident received 3 units of treatment and the number of minutes are not noted? Can we multiply the number of units by 15 minutes to determine the appropriate number of minutes to record on the MDS?

No. The MDS instructions clearly require reporting the actual minutes of therapy received by the patient. Historically, therapy units have been used for billing and have been derived from the actual therapy minutes. For MDS reporting

purposes, conversion from units to minutes is not appropriate, and the actual minutes should be obtained from the therapist's treatment logs. Please note that therapy logs are not an MDS requirement, but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may also be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS.

QUESTION 3 - 74: How would therapy minutes be coded at MDS Item P1bB under each of the following scenarios?

A) A licensed therapist works directly with 2 – 4 residents where each resident is performing the same modality, e.g., upper body strengthening. The treatment ends 30 minutes after it starts.

For each session, record 30 minutes therapy time for each resident at MDS Item P1bB. A maximum of 25% of the resident's therapy time can be delivered in groups.

B) A licensed therapist starts work directly with one resident to start them on a specific task. Once the resident can proceed with supervision, the licensed therapist works directly with a second resident to get them started on a different task, while continuing to supervise the first resident. The treatment ends for each resident 30 minutes after it begins.

For each session, record 30 minutes therapy time for each resident at MDS Item P1bB.

C) Two licensed therapists, each from a different discipline, begin treating one resident at the same time. The treatment ends 30 minutes after it starts.

For each session, record 30 minutes total therapy time for the resident at MDS Item P1b. Split the time between the two disciplines as appropriate, for example, PT = 20 minutes, OT = 10 minutes; or PT = 15 minutes, OT = 15 minutes, etc. In the first example, where the beneficiary received 20 minutes of PT and only 10 minutes of OT, for each session code 1 day of PT at Item P1bA and 20 minutes of PT at Item P1bB. Also code the 10 minutes of OT in P1bB. In this example, no days may be coded for OT at Item P1bA, because the sessions only lasted 10 minutes.

QUESTION 3 - 75: When coding MDS Item P1bB, how would MDS minutes be determined when the therapist starts the session, and delegates the performance of the 30 minute therapy treatment to a therapy aide? The

therapist maintains line of sight supervision during the entire therapy session.

The services of aides performing therapy treatments may only be coded when the services are performed under line of site supervision by a licensed therapist. This type of coordination between the licensed therapist and therapy aide under the direct, personal (e.g., line of sight) supervision of the therapist is considered individual therapy for counting minutes. In the above scenario, include all 30 minutes of the therapy session in MDS Item P1bB.

QUESTION 3 - 76: Do therapists need to record the actual therapy minutes by modality on the therapy service logs? Is this required for MDS? For billing?

Documentation by HCPCS code (indicating the number of minutes per modality) is not required for MDS purposes. Report the total number of therapy minutes the resident received in the 7-day observation period.

When billing for Part A services, therapy units and dollars are reported by revenue code. It is not required to specify the modalities provided. However, when billing Part B therapy services to Medicare, it is necessary to show the specific CPT codes and units for each modality. Billing instructions for Part B therapy services can be found in Program Memorandum AB-01-56.

QUESTION 3 - 77: A facility provides maintenance therapy as described in section 214.3(e) of the Skilled Nursing Facility Provider Manual. The therapist establishes the program. As skilled service, the time spent developing the program is included on the MDS at Item P1b. Once the therapy aides are carrying out the established program, may the minutes of maintenance "therapy" that they provide be counted at MDS at Item P1b?

No. Once the licensed therapist has designed a maintenance program, and discharged the resident from the rehabilitation (i.e., skilled) therapy program, the services performed by the aide should no longer be reported on the MDS at Item P1b as skilled therapy. The services of the aide may be reported on the MDS as restorative nursing, at MDS Item P3, provided they meet the requirements for restorative therapy, i.e., documented measurable objectives, periodic evaluation by licensed nurse, etc.

There may be situations where nursing staff request assistance from a licensed therapist to evaluate the restorative nursing aides or to recommend changes to a restorative nursing program. Consultation with nursing staff and staff training are certainly good clinical practice, but the minutes may not be reported on the MDS as skilled therapy.

QUESTION 3 – 78: Does a resident have to be covered by Medicare Part A in order to code MDS Item P1e (Monitoring acute medical condition)? Or conversely, should Item P1e be checked for all Part A covered beneficiaries?

No. According to the RAI User's Manual, page 3-149, Item P1e should be checked when a resident requires observation by a licensed nurse for ANY acute physical or psychiatric illness. This is a determination regarding the resident's clinical status. Payer source is not a factor. If a resident has a clinical condition that meets the coding criteria in the User's Manual, Item P1e should be checked whether or not the resident is covered by Medicare Part A.

QUESTION 3 - 79: Can the active or passive movement by the resident that is incidental to dressing, bathing, etc., count as active or passive range of motion when coding MDS Item P3?

No. The active or passive movement by a resident that is incidental to dressing, bathing, etc. does not count as part of a formal restorative care program. For inclusion at MDS Item P3, active or passive range of motion must be a component of an individualized program with measurable objectives and periodic evaluation delivered by staff specifically trained in the procedures. Please consult the MDS User's Manual, page 3–153 – 3-157 for a complete description of a restorative care program.

QUESTION 3 - 80: We have a 'total care' resident who has no voluntary or involuntary movement. We place him in a Geri-chair to get him out of bed and out of his room. When he is in bed, we put the side rails up, and we don't consider them restraints or code them on the MDS. Should we code the Geri-chair as a "Chair Prevents Rising" at MDS Item P4e?

For a resident who has no voluntary or involuntary movement, the Geri-chair does not meet the definition of a restraint and should not be coded at Item P4e. While the bed rails may not constitute a restraint, they may affect a resident's quality of life. Bed rails become a visual barrier for these residents and may deter physical contact from others.

QUESTION 3 - 81: We have a resident who cannot walk, but is able to sit up in a Geri-chair. Should we code this at MDS Item P4e as a "Chair Prevents Rising"?

If the resident has the ability to transfer from other chairs, but cannot transfer

from a Geri-chair, the Geri-chair is a restraint to that individual, and should be coded at Item P4e. If the resident has no ability to transfer independently, then the Geri-chair does not meet the definition of a restraint, and should not be coded at Item P4e.

QUESTION 3 - 82: Can a resident, family member, legal representative or surrogate request that a restraint be used?

While a resident, family member, legal representative or surrogate may request that a restraint be used; the facility has the responsibility to evaluate the appropriateness of that request, as they would a request for any type of medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative or surrogate has the right to refuse treatment but not to demand its use when it is not deemed medically necessary. According to the Code of Federal Regulation (CFR) at 42 CFR 483.13(a), AThe resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. The guidelines in the State Operations Manual (SOM) state, A...the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of regulation solely based on a legal surrogate or a representative's request or approval. The SOM goes on to state, AWhile Federal regulations affirm a resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical interventions or treatments that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions.

QUESTION 3 - 83: Does CMS prohibit the use of restraints or bed rails?

The regulations and CMS' guidelines do not prohibit the use of restraints in nursing homes except when they are imposed for discipline or convenience and not required to treat the resident's medical symptoms. The regulation states, AThe resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms (42 CFR 483.13(a)). Research and standards of practice show that the belief that restraints ensure safety is often unfounded. In practice, restraints have many negative side effects and risks that, in some cases, far outweigh any possible benefit that can be derived from their use. If a restraint is needed to treat the resident's medical symptom, the facility is responsible to assess the appropriateness of that restraint. Prior to using any restraint, the facility must assess the resident to properly identify the resident's

needs and the medical symptom that the restraint is being employed to address. The assessment must take into consideration the risks of using the device and the feasibility of employing an alternate, less restrictive means to accomplish the desired outcome. When the decision is made to use a restraint, CMS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use. While a restraint-free environment is not a federal requirement, the use of restraints should be the exception, not the rule.

QUESTION 3 - 84: Does documenting that the side rail (partial or full) is used for positioning or to aid in mobility mean that the side rail is not a restraint?

Not necessarily. In classifying any device as a restraint, the assessor must consider the effect the device has on the individual - not the purpose or intent of its use. It is possible for a device to improve the resident's mobility and also have the effect of restraining the individual. If the side rail has the effect of restraining the resident, the facility is responsible to assess the appropriateness of that restraint. Prior to employing any restraint, the facility must assess the resident to properly identify the resident's needs and the medical symptom the restraint is being employed to address. The assessment must take into consideration the risks of using the device and the feasibility of employing an alternate, less restrictive means to accomplish the desired outcome. When the facility decides that a restraint is needed to treat the resident's medical symptom, CMS encourages, to the extent possible, gradual restraint reduction because of the many negative outcomes associated with restraint use. When a bed rail is *both* a restraint *and* a transfer or mobility aid, it should be coded at MDS Item P4 (a or b, as appropriate), *and* at MDS Item G6b (Bedrails used for mobility or transfer).

QUESTION 3 - 85: If a resident is immobile in bed, are side rails (partial or full) considered a restraint?

Physical restraints are defined as "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricts freedom of movement or normal access to one's body." If the resident is immobile and can not voluntarily get out of bed due to a physical limitation and not due to a restraining device or because proper assistive devices were not present, the bed rails do not meet the definition of a restraint.

For residents who have no voluntary movement, staff need to determine if there is any appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others. Some residents have no ability to carry out

voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body toward the edge of the bed. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be done before employing the use of a restraint or side rail. While the bed rails may not constitute a restraint, they may affect the resident's quality of life.

QUESTION 3 - 86: When a Medicare Part A beneficiary returns from a hospital stay, a Medicare Readmission/ Return assessment is done. Are physician visits (Item P7) and physician orders (Item P8) counted from the date of the readmission, or would physician's visits and/or orders prior to or during the hospital stay also be included?

Count only those doctor's orders and/or visits since the date the beneficiary returned from the hospital. Do not count return admission orders, or renewal orders without changes.

QUESTION 3 - 87: Regarding MDS Items P7 and P8, what combinations of physician's visits and orders are used when calculating the RUG-III group?

Qualification for a RUG category requires the physician to have visited on at least one day during the observation period with order changes made on 4 or more days. If the physician visited on two or more days, the minimum number of days requiring order changes is reduced to 2.

QUESTION 3 - 88: How are MDS Items P7 (Physician Visits) and P8 (Physician Orders) coded when, in the observation period, the physician changes 2 orders in a single visit?

Physician order changes are tallied by the number of DAYS changes are made, not the number of orders changed. In the above scenario, MDS Item P8, (Physician Orders), should be coded "01", since the order changes all occurred on one day. Item P7, (Physician Visits), should be coded "01", since the physician visited one day during the observation period.

QUESTION 3 - 89: Which physician orders can be included when coding MDS Item P8 (Physician Orders)? For example, can we include the monthly Medicare Certification as an order?

A monthly Medicare Certification is a renewal of an existing order, and should not

be included when coding Item P8. The following instructions are excerpted from the RAI User's Manual, page 3 –161: "Physician orders — Includes written, telephone, fax, or consultation orders for new or altered treatment. This does NOT include admission orders, return admission orders, or renewal orders without changes."

QUESTION 3 - 90: When we provide service to a resident based on a PRN order, we notify the physician by preparing a phone order and ask the doctor to countersign it. Can we count this notification as a physician order when coding MDS Item P8?

No. Since the PRN order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does not constitute a new or changed order, and may not be counted when coding Item P8.